ORIGINAL

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BEFORE THE
CALIFORNIA BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **ANDREW FERNANDO REED** 2133 Whitewood Drive Santa Rosa, California 95407 Registered Nurse License No. 609399 Respondent.	**CASE NO. 2004-340** **DEFAULT DECISION AND ORDER**

Respondent **ANDREW FERNANDO REED** (hereinafter referred to as "Respondent Reed") having been served with an initial Accusation, Statement to Respondent, Request for Discovery, Notice of Defense form (two copies) as provided by California Government Code sections 11503 and 11505, and a copy the Discovery Statutes, Government Code sections 11507.5, 11507.6 and 11507.7, and Respondent Reed having filed a Notice of Defense, and subsequently Respondent Reed having been served with a First Amended Accusation and a Supplemental Statement to Respondent, and thereafter, Respondent Reed having been served with Second Amended Accusation, Request for Discovery and second Supplemental Statement to Respondent, and a Notice of Hearing, dated March 29, 2006, having also been served upon Respondent Reed wherein the date, time and place for a Hearing before an Administrative Law Judge was set forth, a Hearing was convened at the date, time and place stated in the Notice of Hearing, to wit: April 17, 2006, at 1:00 P.M., in the Office of Administrative Hearings, 560 J Street, Suite 300. Sacramento, California..

The purpose of the Hearing was to permit the Complainant to present evidence in support of the allegations stated in the Second Amended Accusation, and to afford Respondent Reed with an opportunity to present evidence in contravention of the allegations in the Second Amended Accusation. Respondent Reed having failed to appear at the Hearing, the Administrative Law Judge presiding at the Hearing opened the record of the Hearing and reviewed the documentation concerning the service of process of the Notice of Hearing, dated March 29, 2006. The Administrative Law Judge having determined the service of process of the Notice of Hearing was proper and in accord with the Government Code, the Deputy Attorney General representing the Complainant at the Hearing requested the matter be referred to the California Board of Registered Nursing for the purpose of preparing and adopting a Default Decision and Order.

The Board of Registered Nursing duly accepts the finding of the Administrative Law Judge that the Notice of Hearing, dated March 29, 2006, was properly served on Respondent Reed and that Respondent Reed failed to appear at the time, date and place set for the Hearing. Consequently, the Board of Registered Nursing determines that Respondent Reed has forfeited his right to a Hearing to contest the merits of the Second Amended Accusation; that Respondent Reed is in default; and that this Board will take action on the Second Amended Accusation and evidence herein without a Hearing, and makes the following findings of fact:

FINDINGS OF FACT

1. The Second Amended Accusation was made and filed on November 15, 2005, by the Complainant Ruth Ann Terry, M.P.H., R.N., solely in her capacity as the Executive Officer of the California Board of Registered Nursing ("Board"), against Respondent Andrew Fernando Reed, Registered Nurse License No. 609399.

2. On November 18, 2002, the Board issued Registered Nursing License Number 609399 to Respondent Andrew Fernando Reed. The Respondent's License was in full force and effect at all times relevant to the allegations in the Second Amended Accusation and will expire on April 30, 2006, unless renewed.

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3. Respondent Reed has subjected his license to disciplinary action under Business and Professions Code section 2700, et seq., the Nurse Practicing Act, on the basis of the following grounds:

A. Business and Professions Code section 2761, subdivision (f); in that on October 6, 2004, in the Superior Court, County of Sonoma, in the case entitled ***People of the State of California vs. Andrew Fernando Reed***, (Super. Ct., 2004, Case No. MCR 448184, Respondent Reed was convicted of crimes substantially related to the qualifications, functions, or duties of a licensed registered nurse in that he pled guilty to violating Penal Code section 484, subdivision (a) (unlawfully steal, take away, and carry away the personal property of another, to wit, Santa Rosa Convalescent Hospital), and Respondent Reed was convicted by the court on his plea of no contest to violating Vehicle Code section 23152, subdivision (a) (unlawfully, while under the influence of an alcoholic beverage and a drug and under their combined influence, drive a vehicle).

B. Business and Professions Code section 2762, subdivision (c); in that Respondent Reed was convicted of crimes involving alcohol and controlled substances, as set forth in subparagraph a. above.

C. Business and Professions Code section 2762, subdivision (d); in that pursuant to the convictions set forth in subparagraph a. above, Respondent Reed has been committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of controlled substances.

D. Business and Professions Code section 2762, subdivision (a); in that on or about August 24, 2004, Respondent Reed possessed Ambien, Lorazepam, and Oxycontin, all controlled substances, in violation of Health and Safety Code section 4060, and self administered unknown controlled substances.

E. Business and Professions Code section 2762, subdivision (b); in that on or about August 24, 2004, Respondent Reed used alcoholic beverages and controlled substances to an extent or in a manner dangerous or injurious to himself or others, as set forth in subparagraph a above.

F. Business and Professions Code section section 2762, subdivision (a); in that, while on duty as a registered nurse at Doctors Medical Center, San Pablo, California, Respondent Reed obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law in the following manner:

1. On or about November 18, 2002 through November 23, 2002, Respondent Reed possessed Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, all controlled substances, without a prescription therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

2. On or about November 18, 2002 through November 23, 2002, Respondent Reed obtained Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, all controlled substances, by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a)(1).

G. Business and Professions Code section 2762, subdivision (e); in that, while on duty as a registered nurse at Doctors Medical Center in San Pablo, California, Respondent Reed falsified, made grossly incorrect or grossly inconsistent entries in a hospital, patient, or other record pertaining to a controlled substance as follows:

1. **Pertaining to an individual referred to as "Patient A" in the records of Doctors Medical Center, San Pablo;**

   a. On or about November 18, 2002, at approximately 1541 hours, Respondent Reed obtained 2 tabs of Norco for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

   b. On or about November 19, 2002, at approximately 1158 hours, Respondent Reed obtained a 4 mg. dose of Dilaudid for administration to

Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

c. On or about November 19, 2002, at approximately 1457 hours, Respondent Reed obtained a 4 mg. dose of Dilaudid for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

d. On or about November 19, 2002, at approximately 1753 hours, Respondent Reed obtained a 4 mg. dose of Dilaudid for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

e. On or about November 20, 2002, at approximately 1303 hours, Respondent Reed obtained 2 tabs of Norco for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

f. On or about November 20, 2002, at approximately 0845 hours, Respondent Reed obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

g. On or about November 20, 2002, at approximately 1252 hours, Respondent Reed obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

h. On or about November 20, 2002, at approximately 1253 hours, Respondent Reed obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient A, or otherwise account for the disposition of the medication in any hospital record.

2. **Pertaining to an individual referred to as "Patient B" in the records of Doctors Medical Center, San Pablo;**

a. On or about November 18, 2002, at approximately 0842 hours, Respondent Reed obtained a 4 mg. 1ml. dose of Morphine Sulphate for administration to Patient B; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

b. On or about November 18, 2002, at approximately 1328 hours, Respondent Reed obtained a 4 mg. lml. dose of Morphine Sulphate for administration to Patient B; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

c. On or about November 29, 2002, at approximately 1627 hours, Respondent Reed obtained a 30 mg. syringe of Morphine for

administration to Patient B; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

d. On or about November 20, 2002, at approximately 1712 hours, Respondent Reed obtained a 30 mg. syringe of Morphine for administration to Patient B; however, Respondent Reed failed to properly chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

e. On or about November 21, 2002, at approximately 1030 hours, Respondent Reed obtained 2 tabs of Vicodin for administration to Patient B; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

f. On or about November 23, 2002, at approximately 1756 hours, Respondent Reed obtained 2 tabs of Vicodin for administration to Patient B; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient B, or otherwise account for the disposition of the medication in any hospital record.

3. **Pertaining to an individual referred to as "Patient C" in the records of Doctors Medical Center, San Pablo;**

a. On or about November 22, 2002, at approximately 1345 hours, Respondent Reed obtained 10 mg. of Morphine Sulphate for administration to Patient C; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record

for Patient C, or otherwise account for the disposition of the medication in any hospital record.

b. On or about November 22, 2002, at approximately 1657 hours, Respondent Reed obtained 10 mg. of Morphine Sulphate for administration to Patient C; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient C, or otherwise account for the disposition of the medication in any hospital record.

4. **Pertaining to an individual referred to as "Patient D" in the records of Doctors Medical Center, San Pablo;**

a. On or about November 20, 2002, at approximately 1232 hours, Respondent Reed obtained a 30 mg. syringe of Morphine for administration to Patient D; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient D, or otherwise account for the disposition of the medication in any hospital record.

b. On or about November 20, 2002, at approximately 1743 hours, Respondent Reed obtained a 30 mg. syringe of Morphine for administration to Patient D; however, Respondent Reed failed to chart the administration of the medication in the Medication Administration Record for Patient D, or otherwise account for the disposition of the medication in any hospital record.

H. Business and Professions Code section 2762, subdivision (a); in that, while on duty as a registered nurse at Enloe Medical Center, Chico, California, Respondent Reed obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law as follows:

1.. On or about December 29, 2003 through January 4, 2004, Respondent Reed possessed Morphine Sulphate, a controlled substance, without a prescription

therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

2. On or about December 29, 2003 through January 4, 2004, Respondent Reed obtained Morphine Sulphate, a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a).

I. Business and Professions Code section 2762, subdivision (e), in that on or about January 1, 2004, while on duty as a registered nurse at Enloe Medical Center in Chico, California, Respondent Reed made grossly incorrect or grossly inconsistent entries in a hospital, patient, or other records pertaining to controlled substances when he obtained 4 mg. of Morphine Sulphate for administration to a patient that was not assigned to him. Respondent Reed failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

J. Business and Professions Code section 2762, subdivision (a); in that between approximately February 23, 2005, through March 3, 2005, while on duty as a registered nurse at Novato Community Hospital, Novato, California, Respondent Reed committed acts as follows:

1. Respondent Reed obtained Morphine, Demerol, and Dilaudid, all controlled substances, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173, subdivision (a).

2. Respondent Reed possessed Morphine, Demerol, and Dilaudid, all controlled substances, in violation of Health and Safety Code section 4060.

K. Business and Professions Code section 2752 subdivision (e); in that from approximately February 23, 2005, through March 3, 2005, while on duty as a registered nurse at Novato Community Hospital, Novato, California, Respondent Reed falsified or made grossly incorrect, inconsistent, or unintelligible entries in hospital or patient records regarding

controlled substances as follows:

1. **Pertaining to an individual referred to as "Patient 1" in the records of Novato Community Hospital, Novato;**

a. On or about February 24, 2005, at 2205 hours, Respondent Reed signed out of the Pyxis 2 mg. of Morphine for Patient 1. Respondent Reed charted the administration of 2 mg. of Morphine in the Medication Administration Record for Patient 1 at 2200 hours (5 minutes prior to signing the drug out of the Pyxis); however, he failed to chart the effect of the drug in the Nurse's Notes.

b. On or about February 25, 2005, at 0024 hours, Respondent Reed signed out of the Pyxis 2 mg. of Morphine for Patient 1. Respondent Reed charted the administration of 2 mg. of Morphine in the Medication Administration Record for Patient 1 at 0000 hours (24 minutes prior to signing the drug out of the Pyxis); however, he failed to chart the effect of the drug in the Nurse's Notes.

c. On or about February 25, 2005, at 0053 hours, Respondent Reed signed out of the Pyxis 50 mg. of Demerol for Patient 1; however, there was no physician's order for Demerol for Patient 1. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 50 mg. of Demerol in any hospital record.

d. On or about February 25, 2005, at 0304 hours, Respondent Reed signed out of the Pyxis 100 mg. of Demerol for Patient 1; however, there was no physician's order for Demerol for Patient 1. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 100 mg. of Demerol in any hospital record.

f. On or about February 25, 2005, at 0601 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid for Patient 1; however, there was no physician's order for Dilaudid for Patient 1 and, pursuant to Respondent

Reed's charting in the Nurse's Notes, Patient 1 had passed away at 0333 hours. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

2. **Pertaining to an individual referred to as "Patient 2" in the records of Novato Community Hospital, Novato;**

a. On or about February 24, 2005, at 2320 hours, Respondent Reed signed out of the Pyxis 4 mg. of Morphine for Patient 2; however, Respondent Reed failed to chart the administration or wastage of the drug in the Medication Administration Record for Patient 2 or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

b. On or about February 27, 2005, at 2311 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid for Patient 2; however, there was no physician's order for Dilaudid for Patient 2. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

3. **Pertaining to an individual referred to as "Patient 3" in the records of Novato Community Hospital, Novato;**

a. On or about February 23, 2005, at 0009 hours, Respondent Reed signed out of the Pyxis 2 mg. of injectable Dilaudid for Patient 3; however, there was no physician's order for injectable Dilaudid for Patient 3. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

4. **Pertaining to an individual referred to as "Patient 5" in the records of Novato Community Hospital, Novato;**

a. On or about February 24, 2005, at 0509 hours, Respondent Reed signed out of the Pyxis 4 mg. of Morphine for Patient 5; however, Respondent

Reed failed to chart the administration or wastage of the drug in the patient's Medication Administration Record or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

b. On or about February 24, 2005, at 0628 hours, Respondent Reed signed out of the Pyxis 2 mg. of Morphine for Patient 5; however, Respondent Reed failed to chart the administration or wastage of the drug in the patient's Medication Administration Record or otherwise account for the disposition of the 2 mg. of Morphine in any hospital record.

5. **Pertaining to an individual referred to as "Patient 6" in the records of Novato Community Hospital, Novato;**

a. On or about February 28, 2005, at 0419 hours, Respondent Reed signed out of the Pyxis 100 mg. of Demerol for Patient 6; however, there was no physician's order for Demerol for Patient 6. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 100 mg. of Demerol in any hospital record.

b. On or about March 1, 2005, at 1623 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid for this Patient 6; however, there was no physician's order for Dilaudid for this patient. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

6. **Pertaining to an individual referred to as "Patient 8" in the records of Novato Community Hospital, Novato;**

a. On or about March 3, 2005, at 2314 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid, for Patient 8; however, there was no physician's order for Dilaudid for Patient 8. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

7. **Pertaining to an individual referred to as "Patient 9" in the records of**

Novato Community Hospital, Novato;

a. On or about February 28, 2005, at 0656 hours, Respondent Reed signed out of the Pyxis 50 mg. of Demerol for Patient 9; however, there was no physician's order for Demerol for Patient 9. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 50 mg. of Demerol in any hospital record.

8. Pertaining to an individual referred to as "Patient 11" in the records of Novato Community Hospital, Novato;

a. On or about February 27, 2005, at 2325 hours, Respondent Reed signed out of the Pyxis 4 mg. of Morphine for Patient 11; however, there was no physician's order for Morphine for Patient 11. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

9. Pertaining to an individual referred to as "Patient 13" in the records of Novato Community Hospital, Novato;

a. On or about March 1, 2005, at 1829 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid for Patient 13; however, there was no physician's order for Dilaudid for Patient 13. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

b. On or about March 1, 2005, at 2048 hours, Respondent Reed signed out of the Pyxis 2 mg. of Dilaudid for Patient 13; however, there was no physician's order for Dilaudid for Patient 13. Respondent Reed failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

L. Business and Professions Code section 2761, subdivision (a)(4); in that pursuant to a Stipulation and Consent Order between Respondent Reed and the State of Minnesota, Board of Nursing, by order dated December 4, 2003, the Minnesota Board of Nursing

placed Respondent Reed's State of Minnesota registered nurse license, numbered 149375-5, on suspended status. The factual basis for the disciplinary action by the Minnesota Board of Nursing included Respondent Reed's admitted diversion of controlled substances, including Demerol, Morphine, Meperidine, and Hydromorphone, from his places of employment as a registered nurse in Minnesota, and his practice of nursing in violation of a stipulation between Respondent Reed and the Minnesota Board of Nursing whereby Respondent Reed.

4. On June 3, 2004, Complainant caused to be sent to Respondent Reed, through First Class mail with postage thereon fully paid, the following documents: Statement to Respondent, Accusation, Notice of Defense (2 copies), Request for Discovery, and Discovery Statutes (to wit; California Government Code §§11507.5, 11507.6, and 11507.7). Said documents were sent to Respondent Reed's then current address of record on file with the Board of Registered Nursing, to wit: Andrew Fernando Reed, 2355 Fairview Avenue, No. PMB 186, Roseville, MN 55113. The first class mail was not returned.

5. Additionally, on June 3, 2004, Complainant caused to be sent to Respondent Reed, through Certified mail and return receipt requested (No. 7160 3901 9844 1293 4065), with postage fully paid thereon, the following documents: Statement to Respondent, Accusation, Notice of Defense (2 Copies), Request for Discovery and Discovery Statutes (to wit; California Government Code §§11507.5, 11507.6). Said documents were sent to Respondent Reed's then current address of record on file with the Board of Registered Nursing, to wit; Andrew Fernando Reed, 2355 Fairview Avenue, No. PMB 186, Roseville, MN 55113. The Certified mailing receipt was returned bearing the signature of "Randy Jessup."

6. In response, Respondent Reed submitted a Notice of Defense, dated July 6, 2004, wherein his address was stated to be "45 Corrico Road, Florissant, MO 63031." The Notice of Defense was received by the California State Department of Justice on July 19, 2004.

7. Thereafter, on October 21, 2004, Complainant caused to be sent to Respondent Reed, through Certified mail with return receipt requested (No. 7160 3901 9848 2213 1092), at his then current address of record on file with the Board of Registered Nursing, to

wit; Andrew Fernando Reed, Post Office Box 1244, Florissant, MO 63034, the following documents: Supplemental Statement to Respondent and First Amended Accusation. The Certified mailing receipt was returned bearing the signature of "Lucy Reed."

8. Thereafter, on November 16, 2005, Complainant caused to be sent to Respondent Reed, through first class mail with postage fully paid and Certified mail with return receipt requested (No. 7099 3220 0006 1237 4823), at his current address of record on file with the Board of Registered Nursing, to wit; 2133 Whitewood Drive, Santa Rosa, California 94407, the following documents: Second Amended Accusation, Request for Discovery and Supplemental Statement to Respondent. The Certified mailing was returned to the California State Department of Justice with a label stating "Return to Sender No Forward Order on file Unable to Forward Return to Sender." Also on the Certified mailing envelope was a hand-written notation stating "Return to Sender Moved in July/2005." The first class mailing was not returned.

9. On March 29, 2006, Complainant caused to be sent to Respondent Reed at his current address of record with the Board of Registered Nursing, to wit; 2133 Whitewood Drive, Santa Rosa, California 95407, via First Class and Certified mail with return receipt requested, postage fully paid on both, a Notice of Hearing, dated March 29, 2006, setting forth the date, time and place of the Hearing in the Matter of the Second Amended Accusation Against Andrew Fernando Reed. Both the First Class mailing and the Certified Mailing with return receipt requested were returned to the California State Department of Justice.

10. At the date, time and place stated in the Notice of Hearing, dated March 29, 2006, in the Matter of the Second Amended Accusation Against Andrew Fernando Reed, Respondent Reed failed to appear.

11. Board of Registered Nursing has incurred Costs of Investigation and Prosecution in this matter in the amount of eight thousand forty one dollars and fifty cents ($34,707.50). The Costs of Investigation and Prosecution were reasonable and necessary. Attached as Exhibit "A" to the Declaration of Deputy Attorney General Robert Browning Miller In Support of Default Decision is a Declaration of Investigation and Prosecution Costs by

Deputy Attorney General Robert B. Miller. Exhibit "A" to the Declaration of Deputy Attorney General Robert Browning Miller in Support of Default Decision describes the work effort put forth in this matter.

DETERMINATION OF ISSUES

Based on the foregoing Findings of Fact, Respondent Reed's license is subject to discipline under Business and Professions Code section 2761(a) [unprofessional conduct], section 2761 (f) [criminal conviction], section 2762 (c) [criminal conviction involving alcohol and controlled substances], section 2762 (d) [committed or confined for intemperate use of a controlled substance], section 2762 (a) [possessed and self administered controlled substances], section 2762 (b) [used alcoholic beverages and controlled substances to an extent or in a manner dangerous or injurious to himself or others], section 2762 (a) [obtained and possessed controlled substances in violation of law], section 2762 (e) [falsified or made grossly incorrect or grossly inconsistent entries in patient/hospital records] and section 2761 (a)(4) [out of state discipline of licensee].

Based on the foregoing Findings of Fact set forth in the preceding paragraphs, Respondent Reed's license is subject to discipline.

SUFFICIENCY OF PLEADING AND SERVICE OF PLEADING

The Declaration of Deputy Attorney General Robert Browning Miller, attached hereto and incorporated by reference, states that the evidence is sufficient to support the filing of a pleading in this case and that service of the pleading on Respondent was accomplished in accordance with the California Administrative Procedure Act, as set forth in the Government Code.

LOCATION OF RECORD

The record on which this Default Decision and Order is based, is located at the Sacramento office of the California Board of Registered Nursing, Department of Consumer Affairs, State of California.

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ORDER

WHEREFORE, for the aforesaid causes, the Board of Registered Nursing of the State of California makes its order revoking Registered Nursing License No. 609399 issued to Andrew Fernando Reed.

This Decision shall become effective on August 28, 2006

Dated and signed on July 28, 2006.

La Francine N Tate

La Francine Tate, Board President
California Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW FERNANDO REED** **2133 Whitewood Drive** **Santa Rosa, California 95407** Registered Nurse License No. 609399 Respondent..	Case No. 2004-340 OAH No. N2004090121 **SECOND AMENDED ACCUSATION**

Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Second Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

Registered Nurse License

2. On or about November 18, 2002, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 609399 to Andrew Fernando Reed ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2006, unless renewed.

JURISDICTION

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a

temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 118, subdivision (b), provides, in pertinent part, that the suspension, expiration or forfeiture by operation of law of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
>
> (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

7. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as

defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.

(d) Be committed or confined by a court of competent jurisdiction for intemperate use of or addition to the use of any of the substances described in subdivisions (a) and (b) of this section, in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Health and Safety Code section 11350, subdivision (a) provides that except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (a) or (c), or paragraph (1) of subdivision (f) of section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of section 11054, or specified in subdivision (b), (c), or (g) of section 11055, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison.

9. Health and Safety Code section 11173, subdivision (a) provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or

violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. **DRUGS**

"Demerol," a brand of meperidine hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and a dangerous drug under Code section 4022 in that under federal and state law it requires a prescription.

"Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Lortab" is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug under Code section 4022 in that under federal and state law it requires a prescription.

"Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug under Code section 4022 in that under federal and state law it requires a prescription.

"Norco" is a brand of hydrocodone and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(3), and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Roxanol" is a trade name for the narcotic substance Morphine Sulfate (immediate release) and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(m), and a dangerous drug under Code section 4022 in that under federal and state law it requires a prescription.

"Vicodin" is a compound consisting of 5 mg. hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and 500 mg. acetaminophene per tablet.

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FIRST CAUSE FOR DISCIPLINE

(Criminal Conviction)

12. Respondent is subject to discipline under Code section 2761, subdivision (f), in that on October 6, 2004, in the Superior Court, County of Sonoma, in the case entitled *People of the State of California vs. Andrew Fernando Reed,* (Super. Ct., 2004, Case No. MCR 448184), Respondent was convicted of crimes substantially related to the qualifications, functions, or duties of a licensed registered nurse as follows:

a. Respondent was convicted by the court on his plea of guilty to violating Penal Code section 484, subdivision (a) (unlawfully steal, take away, and carry away the personal property of another, to wit, Santa Rosa Convalescent Hospital).

b. Respondent was convicted by the court on his plea of no contest to violating Vehicle Code section 23152, subdivision (a) (unlawfully, while under the influence of an alcoholic beverage and a drug and under their combined influence, drive a vehicle).

13. The circumstances of the crimes for which Respondent was convicted are that on or about August 24, 2004, Respondent was arrested and subsequently convicted for driving a vehicle while under the influence of alcohol and controlled substances. Respondent took the keys to the narcotics cabinets from the Santa Rosa Convalescent Hospital.

SECOND CAUSE FOR DISCIPLINE

(Criminal Conviction Involving Alcohol and Controlled Substances)

14. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (c), in that Respondent has been convicted of crimes involving alcohol and controlled substances, as set forth in paragraph 12, above.

THIRD CAUSE FOR DISCIPLINE

(Committed or Confined for Intemperate Use of a Controlled Substance)

15. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (d), in that pursuant to the convictions set forth in paragraph 12, above, Respondent has been

committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of controlled substances.

FOURTH CAUSE FOR DISCIPLINE

(Possessed and Self Administered Controlled Substances)

16. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), as follows:

On or about August 24, 2004, Respondent possessed Ambien, Lorazepam, and Oxycontin, all controlled substances, in violation of Code section 4060.

On or about August 24, 2004, Respondent self administered unknown controlled substances.

FIFTH CAUSE FOR DISCIPLINE

(Used Alcoholic Beverages and a Controlled Substance to an Extent or in a Manner Dangerous or Injurious to Himself or Others)

17. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (b), in that on or about August 24, 2004, Respondent used alcoholic beverages and controlled substances to an extent or in a manner dangerous or injurious to himself or others, as set forth in paragraph 12, above.

DOCTORS MEDICAL CENTER

SIXTH CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances in Violation of Law)

18. Respondent is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that, while on duty as a registered nurse at Doctors Medical Center, San Pablo, California, Respondent obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law:

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a. On or about November 18, 2002 through November 23, 2002, Respondent possessed Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, all controlled substances, without a prescription therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

b. On or about November 18, 2002 through November 23, 2002, Respondent obtained Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, all controlled substances, by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a)(1).

SEVENTH CAUSE FOR DISCIPLINE

(Made Grossly Incorrect or Grossly Inconsistent Entries in Patient/Hospital Records)

19. Respondent is subject to discipline under section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that, while on duty as a registered nurse at Doctors Medical Center in San Pablo, California, Respondent falsified, made grossly incorrect or grossly inconsistent entries in a hospital, patient, or other record pertaining to a controlled substance as follows:

Patient A

a. On or about November 18, 2002, at approximately 1541 hours, Respondent obtained 2 tabs of Norco for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

b. On or about November 19, 2002, at approximately 1158 hours, Respondent obtained a 4 mg. dose of Dilaudid for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

c. On or about November 19, 2002, at approximately 1457 hours, Respondent obtained a 4 mg. dose of Dilaudid for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication

Administration Record, or otherwise account for the disposition of the medication in any hospital record.

d. On or about November 19, 2002, at approximately 1753 hours, Respondent obtained a 4 mg. dose of Dilaudid for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

e. On or about November 20, 2002, at approximately 1303 hours, Respondent obtained 2 tabs of Norco for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

f. On or about November 20, 2002, at approximately 0845 hours, Respondent obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

g. On or about November 20, 2002, at approximately 1252 hours, Respondent obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

h. On or about November 20, 2002, at approximately 1253 hours, Respondent obtained a 4 mg. dose of Hydromorphone for administration to Patient A; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

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Patient B

i. On or about November 18, 2002, at approximately 0842 hours, Respondent obtained a 4 mg. 1ml. dose of Morphine Sulphate for administration to Patient B; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

j. On or about November 18, 2002, at approximately 1328 hours, Respondent obtained a 4 mg. lml. dose of Morphine Sulphate for administration to Patient B; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

k. On or about November 29, 2002, at approximately 1627 hours, Respondent obtained a 30 mg. syringe of Morphine for administration to Patient B; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

l. On or about November 20, 2002, at approximately 1712 hours, Respondent obtained a 30 mg. syringe of Morphine for administration to Patient B; however, Respondent failed to properly chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

m. On or about November 21, 2002, at approximately 1030 hours, Respondent obtained 2 tabs of Vicodin for administration to Patient B; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

n. On or about November 23, 2002, at approximately 1756 hours, Respondent obtained 2 tabs of Vicodin for administration to Patient B; however, Respondent

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failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

Patient C

o. On or about November 22, 2002, at approximately 1345 hours, Respondent obtained 10 mg. of Morphine Sulphate for administration to Patient C; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

p. On or about November 22, 2002, at approximately 1657 hours, Respondent obtained 10 mg. of Morphine Sulphate for administration to Patient C; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

Patient D

q. On or about November 20, 2002, at approximately 1232 hours, Respondent obtained a 30 mg. syringe of Morphine for administration to Patient D; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

r. On or about November 20, 2002, at approximately 1743 hours, Respondent obtained a 30 mg. syringe of Morphine for administration to Patient D; however, Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

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ENLOE MEDICAL CENTER

EIGHTH CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances in Violation of Law)

20. Respondent's registered nurse license is subject to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that, while on duty as a registered nurse at Enloe Medical Center, Chico, California, Respondent obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law as follows:

a. On or about December 29, 2003 through January 4, 2004, Respondent possessed Morphine Sulphate, a controlled substance, without a prescription therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

b. On or about December 29, 2003 through January 4, 2004, obtained Morphine Sulphate, a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a).

NINTH CAUSE FOR DISCIPLINE

(Made Grossly Incorrect or Grossly Inconsistent Entries in Patient/Hospital Records)

21. Respondent is subject to discipline under Code section 2761, subdivision (a), as defined in Code section 2762, subdivision (e), in that on or about January 1, 2004, while on duty as a registered nurse at Enloe Medical Center in Chico, California Respondent made grossly incorrect or grossly inconsistent entries in a hospital, patient, or other records pertaining to controlled substances when he obtained 4 mg. of Morphine Sulphate for administration to a patient that was not assigned to him. Respondent failed to chart the administration of the medication in the patient's Medication Administration Record, or otherwise account for the disposition of the medication in any hospital record.

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NOVATO COMMUNITY HOSPITAL

TENTH CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances in Violation of Law)

22. Respondent has subjected his license to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between approximately February 23, 2005, through March 3, 2005, Respondent committed acts as follows:

a. Respondent obtained Morphine, Demerol, and Dilaudid, all controlled substances, by fraud, deceit, misrepresentation, or subterfuge, by taking the drugs from hospital supplies, in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed Morphine, Demerol, and Dilaudid, all controlled substances, in violation of Code section 4060.

ELEVENTH CAUSE FOR DISCIPLINE

(Made Grossly Incorrect or Grossly Inconsistent Entries in Patient/Hospital Records)

23. Respondent has subjected his license to discipline under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that from approximately February 23, 2005, through March 3, 2005, Respondent falsified or made grossly incorrect, inconsistent, or unintelligible entries in hospital or patient records regarding controlled substances as follows:

Patient 1

a. On or about February 24, 2005, at 2205 hours, Respondent signed out of the Pyxis 2 mg. of Morphine for this patient. Respondent charted the administration of 2 mg. of Morphine in the patient's Medication Administration Record at 2200 hours (5 minutes prior to signing the drug out of the Pyxis); however, he failed to chart the effect of the drug in the Nurse's Notes.

b. On or about February 25, 2005, at 0024 hours, Respondent signed out of the Pyxis 2 mg. of Morphine for this patient. Respondent charted the administration of 2 mg. of Morphine in the patient's Medication Administration Record at 0000 hours (24 minutes prior to

signing the drug out of the Pyxis); however, he failed to chart the effect of the drug in the Nurse's Notes.

c. On or about February 25, 2005, at 0053 hours, Respondent signed out of the Pyxis 50 mg. of Demerol for this patient; however, there was no physician's order for Demerol for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 50 mg. of Demerol in any hospital record.

d. On or about February 25, 2005, at 0304 hours, Respondent signed out of the Pyxis 100 mg. of Demerol for this patient; however, there was no physician's order for Demerol for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 100 mg. of Demerol in any hospital record.

e. On or about February 25, 2005, at 0601 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid for this patient; however, there was no physician's order for Dilaudid for this patient and, pursuant to Respondent's charting in the Nurse's Notes, the patient had passed away at 0333 hours. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

Patient 2

f. On or about February 24, 2005, at 2320 hours, Respondent signed out of the Pyxis 4 mg. of Morphine for this patient; however, Respondent failed to chart the administration or wastage of the drug in the patient's Medication Administration Record or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

g. On or about February 27, 2005, at 2311 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid for this patient; however, there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

Patient 3

h. On or about February 23, 2005, at 0009 hours, Respondent signed out of the Pyxis 2 mg. of injectable Dilaudid for this patient; however, there was no physician's order for injectable Dilaudid for this patient. Respondent failed to chart the administration or wastage

of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

Patient 5

i. On or about February 24, 2005, at 0509 hours, Respondent signed out of the Pyxis 4 mg. of Morphine for this patient; however, Respondent failed to chart the administration or wastage of the drug in the patient's Medication Administration Record or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

j. On or about February 24, 2005, at 0628 hours, Respondent signed out of the Pyxis 2 mg. of Morphine for this patient; however, Respondent failed to chart the administration or wastage of the drug in the patient's Medication Administration Record or otherwise account for the disposition of the 2 mg. of Morphine in any hospital record.

Patient 6

k. On or about February 28, 2005, at 0419 hours, Respondent signed out of the Pyxis 100 mg. of Demerol for this patient; however, there was no physician's order for Demerol for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 100 mg. of Demerol in any hospital record.

l. On or about March 1, 2005, at 1623 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid for this patient; however, there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

Patient 8

m. On or about March 3, 2005, at 2314 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid, for this patient; however, there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

Patient 9

n. On or about February 28, 2005, at 0656 hours, Respondent signed out of the Pyxis 50 mg. of Demerol for this patient; however, there was no physician's order for

Demerol for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 50 mg. of Demerol in any hospital record.

Patient 11

o. On or about February 27, 2005, at 2325 hours, Respondent signed out of the Pyxis 4 mg. of Morphine for this patient; however, there was no physician's order for Morphine for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 4 mg. of Morphine in any hospital record.

Patient 13

p. On or about March 1, 2005, at 1829 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid for this patient; however, there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

q. On or about March 1, 2005, at 2048 hours, Respondent signed out of the Pyxis 2 mg. of Dilaudid for this patient; however, there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration or wastage of the drug or otherwise account for the disposition of the 2 mg. of Dilaudid in any hospital record.

TWELFTH CAUSE FOR DISCIPLINE

(Out of State Discipline)

24. Respondent is subject to discipline under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that pursuant to a Stipulation and Consent Order between Respondent and the State of Minnesota, Board of Nursing, by order dated December 4, 2003, the Minnesota Board of Nursing placed respondent's registered nurse license number 149375-5 in suspended status. The factual basis for the disciplinary action by the Minnesota Board of Nursing included Respondent's admitted diversion of controlled substances, including Demerol, Morphine, Meperidine, and Hydromorphone, from his places of employment as a registered nurse in Minnesota, and his practice of nursing in violation of a stipulation between Respondent and the Minnesota Board of Nursing whereby Respondent agreed to cease practicing nursing.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 609399, issued to Andrew Fernando Reed;

2. Ordering Andrew Fernando Reed to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/15/05

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer Board of Registered Nursing Department of Consumer Affairs State of California Complainant

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2nd Amend Accu.wpd

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW FERNANDO REED** ~~2355 Fairview Ave. No. PMB 186~~ P.O. Box 1244 ~~Roseville, MN 55113~~ FLORISSANT MO 63034 Registered Nurse License No. 609399 Respondent.	Case No. 2004-340 **FIRST AMENDED ACCUSATION**

Ruth Ann Terry, M.P.H., R.N. (Complainant) alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 18, 2002, the Board of Registered Nursing (Board) issued Registered Nurse License Number 609399 to Andrew Fernando Reed (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2006, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section

2750) of the Nursing Practice Act.

4. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

5. Section 2761 of the Code states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> * * * *
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
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> * * * *

6.. Section 2762 of the Code provides, in pertinent part:

> "In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
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> * * * *

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Health and Safety Code section 11350, subdivision (a) provides that except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (b) or (c), or paragraph (1) of subdivision (f) of section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of section 11054, or specified in subdivision (b), (c), or (g) of section 11055, or (2) any controlled substance classified in Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison.

8. Health and Safety Code section 11173, subdivision (a) provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. Section 4022 of the Code provides that the term "dangerous drug" means any drug unsafe for self-use, in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

11. "Norco" is a trade name for hydrocodone and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(3), and a dangerous drug under section 4022 of the Code in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

11. Dilaudid is a trade name for hydromorphone and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision

(b)(1)(K), and a dangerous drug under section 4022 of the Code in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

12. Lortab is a trade name for Hydrocodone and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(3), and a dangerous drug under section 4022 of the Code in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

13. Morphine Sulphate is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(m), and a dangerous drug under section 4022 of the Code in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

14. "Vicodin" is a compound consisting of 500mg. acetaminophene per tablet and 5mg. hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056 and a dangerous drug under section 4022 of the Code in that under federal or state law it can be lawfully dispensed only on prescription or furnished pursuant to section 4006 of the Code.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Doctors Medical Center)

(Obtaining, Possessing, Controlled Substances)

15. Respondent's registered nurse license is subject to disciplinary action under section 2761, subdivision (a), and section 2762, subdivision (a) of the Code, in that, as set forth below, Respondent obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law:

a. On or about November 18, 2002 through November 23, 2002, while employed as a registered nurse at Doctors Medical Center, San Pablo, California, Respondent obtained and possessed Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, without a prescription therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

b.. On or about November 18, 2002 through November 23, 2002, while employed as a registered nurse at Doctors Medical Center, San Pablo, California, Respondent obtained and possessed Norco, Hydromorphone, Dilaudid, Morphine Sulphate, and Vicodin, by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a).

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Enloe Medical Center)

(Obtaining, Possessing, Controlled Substances)

16. Respondent's registered nurse license is subject to disciplinary action under section 2761, subdivision (a), and section 2762, subdivision (a) of the Code, in that, as set forth below, Respondent obtained and possessed controlled substances without prescriptions therefor and without any other legal authority to do so, in violation of law:

a. On or about ~~December 3, 2003~~ 12/29/2003 through January 4, 2004, while employed as a registered nurse at Enloe Medical Center, Chico, California, Respondent obtained and possessed Morphine Sulphate without a prescription therefor and without any other legal authority to do so, in violation of Health and Safety Code section 11350, subdivision (a).

b.. On or about ~~December 3, 2003~~ 12/29/2003 through January 4, 2004, while employed as a registered nurse at Enloe Medical Center, Chico, California, Respondent obtained and possessed Morphine Sulphate by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a).

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Doctors Medical Center)

(False, Grossly Incorrect, or Inconsistent Record Entries)

17. Respondent is subject to disciplinary action under section 2761, subdivision (a) and section 2762, subdivision (c) of the Code in that, as set forth below, Respondent committed the following acts involving false, grossly incorrect, or grossly inconsistent entries in a hospital, patient, or other record pertaining to a controlled substance:

a. **PATIENT A**

1. On or about November 18, 2002, at approximately 1541 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 2 tabs of Norco for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

2. On or about November 19, 2002, at approximately 1158 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Dilaudid for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

3. On or about November 19, 2002, at approximately 1457 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Dilaudid for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

4. On or about November 19, 2002, at approximately 1753 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Dilaudid for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

5. On or about November 20, 2002, at approximately 1303 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 2 tabs of Norco for administration to Patient A. Thereafter,

Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

6. On or about November 20, 2002, at approximately 0845 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Hydromorphone for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

7. On or about November 20, 2002, at approximately 1252 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Hydromorphone for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

8. On or about November 20, 2002, at approximately 1253 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg. dose of Hydromorphone for administration to Patient A. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

b. PATIENT B

1. On or about November 18, 2002, at approximately 0842 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg./ml. dose of Morphine Sulphate for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

2. On or about November 18, 2002, at approximately 1328 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 4mg./ml. dose of Morphine Sulphate for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

3. On or about November 29, 2002, at approximately 1627 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 30mg. syringe of morphine for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

4. On or about November 20, 2002, at approximately 1712 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 30mg. syringe of morphine for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

5. On or about November 21, 2002, at approximately 1030 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 2 tabs of Vicodin for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

6. On or about November 23, 2002, at approximately 1756 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 2 tabs of Vicodin for administration to Patient B. Thereafter, Respondent failed to properly document or record the administration of the medication on the

patient's medication administration record, or to otherwise account for the disposition of the medication.

c. **PATIENT C**

1. On or about November 22, 2002, at approximately 1345 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 10 mg./ml/ of Morphine Sulphate for administration to Patient C. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

2. On or about November 22, 2002, at approximately 1657 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained 10 mg./ml/ of Morphine Sulphate for administration to Patient C. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

d. **PATIENT D**

1. On or about November 20, 2002, at approximately 1232 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 30mg. syringe of morphine for administration to Patient D. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

2. On or about November 20, 2002, at approximately 1743 hours, while on duty as a licensed registered nurse at Doctors Medical Center located in San Pablo, California, Respondent obtained a 30mg. syringe of morphine for administration to Patient D. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Enloe Medical Center)

(False, Grossly Incorrect, or Inconsistent Record Entries)

18. Respondent is subject to disciplinary action under section 2761, subdivision (a) and section 2762, subdivision (e) of the Code in that, as set forth below, Respondent committed the following acts involving false, grossly incorrect, or grossly inconsistent entries in a hospital, patient, or other record pertaining to a controlled substance:

19. On or about January 1, 2004, while on duty as a registered nurse at Enloe Medical Center in Chico, California, Respondent obtained 4 mg. of Morphine Sulphate for administration to a patient that was not assigned to him. Thereafter, Respondent failed to properly document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

FIFTH CAUSE FOR DISCIPLINE

(Out of State Discipline)

10. Respondent has subjected his Registered Nurse License to discipline under section 2761(a)(4) of the Code, in that pursuant to a Stipulation and Consent Order between respondent and the State of Minnesota, Board of Nursing, by order dated December 4, 2003, the Minnesota Board of Nursing placed respondent's registered nurse license number 149375-5 in suspended status. The factual basis for the disciplinary action by the Minnesota Board of Nursing included respondent's admitted diversion of controlled substances, including Demerol, Morphine, Meperidine, and Hydromorphone, from his places of employment as a registered nurse in Minnesota, and his practice of nursing in violation of a stipulation between respondent and the Minnesota Board of Nursing whereby respondent agreed to cease practicing nursing.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 609399 issued to Andrew Fernando Reed;

2. Ordering Andrew Fernando Reed to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3 Taking such other and further action as deemed necessary and proper.

DATED: _____

_____

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2004101568

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ANDREW FERNANDO REED** **2355 Fairview Ave. No. PMB 186** **Roseville, MN 55113** Registered Nurse License No. 609399 Respondent.	Case No. 2004-340 **A C C U S A T I O N**

Ruth Ann Terry, M.P.H., R.N. (Complainant) alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about November 18, 2002, the Board of Registered Nursing (Board) issued Registered Nurse License Number 609399 to Andrew Fernando Reed (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2006, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section

2750) of the Nursing Practice Act.

4. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

5. Section 2761 of the Code states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> . . . .
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Out of State Discipline)

7. Respondent has subjected his Registered Nurse License to discipline under section 2761(a)(4) of the Code, in that pursuant to a Stipulation and Consent Order between respondent and the State of Minnesota, Board of Nursing, by order dated December 4, 2003, the Minnesota Board of Nursing placed respondent's registered nurse license number 149375-5 in suspended status. The factual basis for the disciplinary action by the Minnesota Board of Nursing included respondent's admitted diversion of controlled substances, including Demerol, Morphine, Meperidine, and Hydromorphone, from his places of employment as a registered nurse in Minnesota, and his practice of nursing in violation of a stipulation between respondent

and the Minnesota Board of Nursing whereby respondent agreed to cease practicing nursing.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 609399 issued to Andrew Fernando Reed;

2. Ordering Andrew Fernando Reed to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3 Taking such other and further action as deemed necessary and proper.

DATED: 5/26/04

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2004101568